Bureau of Health Care Quality and Compliance

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING B. WING				
	NVN4271NSP	0.00000	2500 0171/ 074	TE 710 0005	06/28/2010		
OVIDER OR SUPPLIER							
NURSING LLC							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (2)			
00 INITIAL COMMENTS			P 000				
This Statement of Deficiencies was generated as a result of a State Relicensure focused survey conducted in your facility on 06/17/10 and finalized on 6/28/10, in accordance with Nevada Administrative Code, Chapter 449, Nursing Pools.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.							
receptionist at the entreceptionist stated that Pool was not occupie anyone being at the chours. (Monday throut 5-6 PM) The reception contact phone number not aware of any files	trance of the building.  at the office of the Nursed and she was not away  office during normal office of the price of the	The ing are of ce ugh s a was iffice					
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The receptionist stated that the office of the Nursing Pool was not occupied and she was not aware of anyone being at the office during normal office hours. (Monday through Friday, 8-9 AM through 5-6 PM) The receptionist stated that she has a contact phone number that is not local. She was not aware of any files that were kept in the office or any computer equipment that was in the office.  449.7473 USE OF LICENSE  1. Each license is separate and distinct and is issued to a specific person to operate a nursing pool must be operated and conducted under the name and within the area of service designated on the license. The name of the person who is designated as responsible for its conduct must appear on the face of the	STREET ADDRESS, CITY, STA  955 SOUTH VIRGINIA ST  RENO, NV 89502   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  P 000  This Statement of Deficiencies was generated as a result of a State Relicensure focused survey conducted in your facility on 06/17/10 and finalized on 6/28/10, in accordance with Nevada Administrative Code, Chapter 449, Nursing Pools.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.  The location was an executive office suite with a receptionist at the entrance of the building. 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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 01/11/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM  NVN4271NSP			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
					06/28/2010		
NAME OF PROVIDER OR SUPPLIER	NVN427 INOI	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	00	720/2010	
AUREUS NURSING LLC		955 SOUTH VIRGINIA STREET SUITE 111 RENO, NV 89502					
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
P 043 Continued From page 1	Continued From page 1						
Based on observation, of interview, the facility fails pool facility at the locatic license by the Administraticense in accordance who of the Nevada Revised Stadministrative Code and regulations adopted by the Asite visit was conducted AM. The location was a with a receptionist at the The receptionist stated the Nursing Pool was not on aware of anyone being a office hours. (Monday the through 5-6 PM) The rehas a contact phone nure She was not aware of anyone the office or any compute the office.  On 6/28/10, 12:30 PM, a contact number provided receptionist. An operate stated that there was not there was only one located that there was not there was only one located She was able to connect representative. During the was a discussion about office. The representative was located at the office was explained to the representation of deficiencies would require a plan of a agency before a follow-uconducted. In November main office in Nebraska	Based on observation, documentation review and interview, the facility failed to operate a nursing pool facility at the location documented on the license by the Administrator documented on the license in accordance with Chapter 439 and 449 of the Nevada Revised Statutes and the Nevada Administrative Code and the standards, rules and regulations adopted by the Board of Health.  A site visit was conducted on 6/17/10 at 11:30 AM. The location was an executive office suite with a receptionist at the entrance of the building. The receptionist stated that the office of the Nursing Pool was not occupied and she was not aware of anyone being at the office during normal office hours. (Monday through Friday, 8-9 AM through 5-6 PM) The receptionist stated that she has a contact phone number that is not local. She was not aware of any files that were kept in the office or any computer equipment that was in						

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NAME OF PROVIDER OR SUPPLIER  AUREUS NURSING LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  985 SOUTH VIRGINIA STREET SUITE 111  RENO, NV 89502  (C4)10  (C4)10	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  AUREUS NURSING LLC  SUMMARY STATEMENT OF DEFICIENCIES PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  P 043  Continued From page 2 information that they had been informed in February of 2005 that "our (the Bureau) expectation is that the Director would be "on site" to oversee the daily operations and not ALWAYS available by Internet or phone." At the time of the survey, the expectation of staff in the office was not being met.	NVN4271NSP			B. WING			28/2010		
AUREUS NURSING LLC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  P 043  Continued From page 2  information that they had been informed in February of 2005 that "our (the Bureau) expectation is that the Director would be "on site" to oversee the daily operations and not ALWAYS available by Internet or phone." At the time of the survey, the expectation of staff in the office was not being met.	•			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00.1		
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